BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOHN HENSLER, M.D.** Holder of License No. **5346** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-03-0174A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 5, 2006. John Hensler, M.D., ("Respondent") appeared before the Board with legal counsel Charles Buri for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 5346 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-0174A after receiving a complaint regarding Respondent's care and treatment of a forty-four year old male patient ("RW"). RW was Respondent's patient from February 5, 2001 to March 29, 2002. RW had a complicated past medical history, including hospitalizations for drug abuse, alcohol dependence, paranoid disorder NOS, sedative-hypnotic dependence and prescription opioid dependence. In January 2001 Respondent was admitted to Maricopa Medical Center after an overdose with paranoid and delusional behavior and was hospitalized at Samaritan Behavioral Health in March 2001 for paranoid statements and passive suicidal thoughts with another detoxification from pain

medications. RW did not have direct contact with his family, but lived off a trust set up by his deceased father. As a result of an agreement between RW's lawyer and his mother's lawyer, RW was to continue medical care with Respondent, meet with him at least once per week and follow all Respondent's instructions regarding medicines, pill counts, urine and laboratory work. The agreement allowed Respondent to immediately notify the Court and counsel of any changes, termination or suspension in the physician-patient relationship.

4. Respondent was RW's primary physician during this time and agreed to provide basic medical care and write prescriptions if RW did not seek drugs from other physicians. During the time Respondent treated RW there were 134 office visits and additional numerous phone calls. The majority of the office visits are not well documented and lack an adequate examination, assessment or plan. In some of the charts Respondent notes there was a lengthy discussion, but there is no narrative of what was discussed and what assessment and plan came from the discussion. Respondent's diagnosis list for RW included a history of seizures, bronchitis, asthma, arthritis, edema, barbiturate and narcotic addiction, increased lipids, hypothyroid, increased LFTs, headaches, weight gain, agitation, "panic", anxiety/stress, tachycardia, depression, and others. This list also contains lab abnormalities that are present, including elevated lipids, but does not include a low TSH, which was noted throughout the lab values.

5. RW was also under the care of at least one psychiatrist, but there are no records of any communication between Respondent and the psychiatrist other than sporadically noted telephone calls that do not document what was said during the conversations. Respondent prescribed narcotics and other controlled substances to RW over a one-year time frame and there was an overall increase in RW's use of controlled substances. Respondent ordered numerous and varied lab tests, but most of the time there was no documented reason for the test. In the investigational interview with Board Staff, Respondent stated he did not really profit from

the tests and he ordered them at times because RW wanted them and he could not get RW off the notion of ordering the tests. Respondent also indicated he did not think all the labs were "justifiable" or "reasonable," but that he was just trying to keep his head above water some of the time. Often Respondent did not address lab results, whether they were normal or abnormal. During his investigational interview with Board Staff, Respondent noted he was somewhat fearful of RW and was just trying to help him as best he could.

6. Respondent provided RW with some psychological/psychiatric care and prescribed medications such as anti-depressants, anxiolytics, and sleep aids. Respondent also provided social services, such as calling and arranging payments through the attorney and trust company and arranging transportation. Respondent's early office notes reflect RW went to see psychiatrists, but Respondent's records contain no correspondence from them. Respondent's records reflect RW's behavior became more erratic during the last six months of his care, but Respondent's only psychiatric intervention was a mention of a psychologist in his November 29, 2001 office note. There is no indication whether or not the psychologist was actively seeing RW. Respondent's records also reflect RW continued to have active problems abusing narcotics, alcohol and benzodiazepines. Toward the end of the office visits between RW and Respondent, RW complained of difficulty breathing and was tachycardic over his usual heart rate of approximately 95 to 100. From March 11, 2002 through March 29, 2002 Respondent's office notes indicate RW was having difficulty breathing. Respondent's April 1, 2002 office note states RW "was found dead 4-1-02. . . .I refused to sign death certificate." According to the death certificate RW died on April 1, 2002 with the immediate cause of death listed as bronchopneumonia with significant conditions of combined drug toxicity and ASCVD.

7. Respondent testified RW had a very unique psychological/psychiatric background that he did not become aware of until RW had been his patient for some time. Respondent testified RW was a congenial, pleasant man who could erupt into a situation of demands that

would create chaos at a moment's notice. RW called his office on the Thursday before he died and said he was ill. RW was asked to come to the office on Friday and get an x-ray, but he failed to come in. Respondent spoke with RW again in late morning and RW said he would come in and there were additional phone calls from RW, but he did not arrive by 5:00 p.m. when the X-ray lab closed. Respondent testified he did not have an opportunity to do anything for RW because he completely ignored Respondent's instructions. Respondent testified one thing that made his relationship with RW unique was that RW had a trust that paid his medical bills and he had an agreement with the trust that he would send a statement by facsimile and he would be sent a check the next day. Respondent also prepared Blue Cross billings on RW's behalf and the trust received whatever moneys Blue Cross reimbursed to them.

8. The Board asked Respondent when he was last re-certified in family practice. Respondent testified he attempted re-certification about seven years ago, but he became ill during the recertification and did not complete it. The Board asked Respondent the recommendations of the persons and centers who treated RW for substance abuse in terms of use of opiates and similar addicting medications. Respondent testified RW spent four weeks in 1999 at a psychiatric hospital or detoxification center and he was discharged on most of the same medications he went in on. The Board directed Respondent to a medication list prepared by its medical consultant, specifically to March of 2002 and March 2001.

9. Respondent testified his charge with RW was to stabilize him until a court hearing to determine whether RW was able to care for himself. The Board asked what Respondent was trying to stabilize. Respondent testified he was trying to stabilize a number of mood disorders, trying to help RW with his ongoing back pain, trying to keep him from eating excessively, and trying to help him deal with all the court hearings and attorneys he had to deal with. The Board asked if Respondent believed he was successful. Respondent testified he was within a week of resolving things. The Board asked if it was prudent and within the standard of care of family

practice to treat recovering opiate abusers with Oxycontin and Vicodin. Respondent testified if the patient is in severe pain, he was not quite sure what should be done. The Board asked if Respondent referred RW to a pain consultant. Respondent asked the Board how he would refer someone who refuses a referral. The Board referred to Respondent's problem list for RW and asked about the noted history of seizure disorders. Respondent testified he could not find an instance in all of RW's records of his having had a seizure. The Board asked why then was it written in the problem list. Respondent testified he put the diagnosis down repeatedly because RW stated the reason he needed Fiorinal and Phenobarbital was to prevent seizures.

10. The Board asked Respondent if prescribing barbiturates to a patient with a history of substance abuse and chemical dependency or undocumented cortical seizures meets the standard of care in family medicine. Respondent testified he was not sure you can find standards when someone relates back to pituitary surgery as the onset of their seizure disorder. The Board noted Respondent testified there was no documentation of a seizure disorder. Respondent testified he looked to see if he could find one because he was also alleged to have given RW Paxil and Alteram, which theoretically can increase the frequency of seizures. The Board confirmed Respondent gave RW Alteram and asked him whether the seizure disorder is a contraindication. Respondent testified RW was on Alteram before he met him. The Board noted that was not the question. Respondent testified it was possibly contraindicated depending on how recent RW's seizure had been and that the Physician Desk Reference says that alcohol, any narcotic, any psychotropic drug are all relative contraindications. The Board asked Respondent to describe the mechanism of Paxil. Respondent testified it was a selective serotonin reuptake inhibitor ("SSRI") used in depression. The Board asked if it mixed well with Alteram. Respondent testified it was not a matter of a good mix; there is a potential that it could increase the frequency of seizure. The Board asked why then, he gave a patient with a history of seizures, which

Respondent admits he never investigated, two drugs that are contraindicated in seizures. Respondent testified he did not know RW was on Alteram when he first met him.

11. The Board asked the indication for the multiple CBCs ordered throughout September 2001. Respondent testified RW had an elevated white blood count and was ill when he first started all that and he was trying to see if he could detect improvement. The Board asked what the underlying illness was. Respondent testified RW had bronchitis. The Board asked if it was typical standard of care in family practice to monitor bronchitis with CBCs. Respondent noted RW also had anemia. The Board noted on most of these dates Respondent also ordered liver function tests that came back abnormal and asked Respondent what he did to address RW's abnormal liver function. Respondent testified RW was taking a huge amount of medications and was extremely undependable. As a result, it was difficult to monitor exactly what he was taking. Respondent testified he did pill counts every time RW came into the office and he frequently changed the medications because he knew RW was abusing them. The Board again asked what Respondent did about the abnormalities on the liver function tests. Respondent testified he was monitoring them to make sure they did not become worse. The Board asked what the advantage was to RW in ordering CBC and liver functions, cholesterol panels and thyroid panels four times during September 2001. Respondent testified RW had requested some of the tests. The Board asked if it was the standard of care in family practice to order a test just because the patient requests it. Respondent testified it was not. The Board asked how ordering fifteen cholesterol panels over a period of three months enhanced RW's care. Respondent testified he would have to look at each one individually to tell what it did or did not do.

12. The Board asked if there was any literature suggesting a patient needs fifteen cholesterol tests in three months. Respondent testified they were part of a chem 20 panel and they are not necessarily ordered individually. The Board directed Respondent to the office visit of February 27, 2002, particularly the note "complains of dyspnea. Apparently seems very short of

breath." The Board confirmed RW weighed 300 pounds, had a pulse of 100, and blood pressure of 140 over 90. The Board asked for the standard of care in family practice for evaluating a patient with shortness of breath. Respondent testified he was not quite sure the Board was talking about a single symptom. The Board noted RW complained of, and Respondent noted, shortness of breath and asked Respondent if he recorded anything about the duration of the shortness of breath. Respondent testified RW was short of breath every time he came to his office. The Board asked if Respondent asked RW about chest pain, and the timing, or aggravating or relieving factors for his shortness of breath. Respondent testified when RW came into his office he was short of breath on every occasion and, once he was calmed down, his respiration rate and oxygen rate would return to normal. The Board asked what Respondent recorded as history of present illness – whether he recorded some typical things such as duration, quality, timing, context, smoker, sputum, or history of asthma. Respondent testified he knew all of this from previous visits. The Board asked if the standard in family practice required he document those features so that another physician who had to assume care could look at Respondent's record and make a determination of what was going on with a patient. Respondent testified that with RW another physician would have to look at more than one progress note and if he were seeing RW once in a period of weeks or months he would be writing these things down, but the frequency of visits was almost as if it was recurring day after day after day.

13. The Board directed Respondent to the billing for the February 27, 2002 visit, specifically the bill to the trust for CPT code 99215 and asked Respondent what 99215 signifies in the CPT code. Respondent testified it signified a complete history and physical involving multiple complex illnesses and it should be a very lengthy visit. The Board asked if the code required a past medical history be documented. Respondent testified it did if RW was an individual being seen on an isolated occasion. The Board asked if it required family and social history be recorded. Respondent testified the 99215 has nothing to do with RW's trust and the trust

requested he code things as reasonably as he could to try to help reimbursement and, if there was such a thing as complexity and length of time, on average RW spent two hours in his office. The Board asked what Respondent would have done for two hours. Respondent testified he would listen to RW rant and complain and plot and cry and worry about his upcoming court case. The Board directed Respondent back to the 99215 comprehensive examination code and asked if he records a comprehensive physical examination. Respondent testified he did not. The Board asked if the comprehensive examination was a requirement of 99215. Respondent testified if he were asking Blue Cross or any other agency to pay according to how he was coding he would not have used that code.

14. The Board asked Respondent the standard of care for evaluating a morbidly obese forty-four year-old man who is tachycardic, cannot breathe, and who has had breathing problems for a while. Respondent testified he saw RW in the morning and then again in the afternoon and RW stated he thought he had food with MSG and that was what was causing his symptoms. The Board noted there was a differential diagnosis of dyspnea in a forty-four year-old morbidly obese male. Respondent testified that could include everything from allergies to asthma, COPD, emphysema, pulmonary embolus, congestive heart failure, acute myocardial infarction – a large number of things. The Board noted that sounded reasonable and asked Respondent how he addressed pulmonary embolism. Respondent testified he did not. The Board asked how he addressed myocardial infarction. Respondent testified he just saw RW the morning before. The Board asked how he addressed it then. The Board noted RW was tachypneic, had a respiratory rate of 28 and a heart rate of 120 and asked if Respondent agreed those are not normal. Respondent agreed they were not normal, but noted he had no idea what medication went into RW before he came into the office. The Board confirmed Respondent was aware RW had a history of substance abuse and that he had multiple risk factors for pulmonary embolism, coronary artery disease, pneumonia, and a long list of life-threatening conditions. The Board

asked if Respondent did anything to rule these things out. Respondent asked if the Board was suggesting he do an array of additional studies every time he saw RW. The Board noted it was asking for the standard of care.

15. The Board directed Respondent to his record for the February 28, 2002 office visit where RW reports difficulty breathing and spoke very slowly. The Board asked Respondent what he thought was going on with RW and what he was treating with Kenalog and Benadryl. Respondent testified he was treating the possible allergic reaction or sensitivity to MSG. The Board asked Respondent's criteria for making a diagnosis of possible allergic reaction. Respondent testified RW had been to lunch and ate at a restaurant he thought used MSG. The Board noted RW had been short of breath when Respondent saw him in the morning, before he ate lunch. Respondent testified RW was always short of breath. The Board asked Respondent what he thought was going on during the phone call of the 28th when he noted RW was speaking very slowly and had to think of his words and that he needed to check RW's blood and urine for drugs. Respondent testified RW was calling to see if Respondent would give him more shots and this was the way RW frequently operated. Respondent noted he would have days where RW would call and repeat calls and, if they did not hang up and use another line, he would never get off the line until he got what he wanted. The Board asked if Respondent believed RW had a major psychiatric illness. Respondent testified he do not think RW did while he was seeing him, but RW did have a psychotic break on an occasion in late December and was diagnosed as psychosis NOS. Respondent noted RW was placed under the care of two psychiatrists by court order after the break. Respondent testified he was asked to take part in RW's care, not to treat his psychiatric problems or to cure him of his drug problems, but to try and just keep him together and treat his acute illnesses.

16. The Board asked if it was typical for a family practice doctor to spend one hour and one half or two hours with a patient listening to them rant and rave. Respondent testified it was

not and RW was his first and only experience. The Board noted Respondent saw RW again on March 1, 2002 and a staff person wrote "hands very swollen, can he take Maxzide." The Board asked if Respondent recorded any history of present illness on this date other than what staff wrote. Respondent testified he discussed RW's labs with him and all of his medications were counted. The Board asked if Respondent performed a physical examination. Respondent testified he performed a very limited examination. The Board asked if the visit met the standard for code 99215. Respondent testified he was not applying 99215 to what was going with RW, but it was the situation with the trust. The Board asked why Respondent submitted a CPT code that he admits under oath was not supported. Respondent testified there was not a code that would fit the time and effort, circumstance and complexity that he faced every time RW came to his office.

17. The Board directed Respondent to the visit of March 8, 2002 where RW's weight had gone from 311 pounds one week earlier to 323 pounds and asked Respondent what he thought was going on. Respondent testified he thought RW was trying to fulfill his wish of eating himself to death. The Board asked if RW was suicidal. Respondent testified RW repeatedly said, from the day Respondent met him and suggested he lose weight and exercise, that he did not want to do that and he wanted to eat because it was his life. The Board noted RW was a man with significant depression as well as substance abuse and asked if Respondent had training in psychiatry. Respondent testified RW was under the care of a psychiatrist pursuant to court order for the same year Respondent was treating him under court order. The Board asked if Respondent had any documentation of which psychiatrist was treating RW. Respondent identified one of the psychiatrists. The Board asked the date the last time RW saw a psychiatrist during the March 2002 time period. Respondent testified he did not know off the top of his head, but he thought RW was to be seen every couple of weeks.

18. The Board directed Respondent to the March 11, 2002 office note that says "patient phoned, can't breathe. Wants antibiotic injection, cortisone injection. Speech slurred, very slow." The Board noted "Vicodin" was written on the note with a star or "x" and asked what that signified. Respondent testified he suspected it was the excess Vicodin, extra strength that slurred his speech. Respondent noted RW had only nineteen Vicodin left from a much larger prescription. The Board noted RW had a history of substance abuse and slurred speech, yet Respondent continued to write opiate prescriptions. The Board asked if this was within the standard of care in family practice. Respondent testified he could not see where he did that. The Board noted Respondent gave RW Opian, Paxil, Rocephin and Kenalog and asked what Respondent was treating. Respondent testified RW had a history of asthma and multiple pneumonias and probably had bronchitis again. The Board noted RW was tachycardic and gaining weight and asked Respondent how he knew RW did not have pneumonia on March 11. Respondent testified RW's lungs did not sound like it and his pulse ox did not support it.

19. The Board asked if Rocephin and Kenalog were mainstays in family practice for treatment of asthma. Respondent testified if he was going to give a significant antibiotic to someone who might have pneumonia he thinks they are a very good choice and RW received Kenalog on multiple occasions because Respondent thought he was cortisone deficient. The Board asked if he thought RW had Addison's disease. Respondent testified RW had pituitary surgery when he was twenty years old. The Board asked if Respondent performed an MRI. Respondent testified one had been done two years prior, but Respondent had no record of it. The Board asked the principal modalities for treating asthma in an adult. Respondent testified he would possibly use a bronchodilator, albuterol, or some other hand-held device or Singulair when their attacks are bad. Respondent noted if they had an infection he would give an antibiotic and in RW's case he gave him a Medrol dose pack as well as the injection.

20. The Board noted Respondent gave RW Biaxin in addition to the Rocephin and asked the rationale for mixing two different classes of antibiotics. Respondent testified it quite often helps significantly. The Board asked if it was standard of care in family practice to treat bronchitis with an injection of Rocephin and an oral antibiotic. Respondent testified with RW and all as his complexities he thought it was very appropriate. The Board noted that RW continued to gain weight, his heart rates kept going up, and he died from bronchopneumonia with secondary diagnosis of substance abuse and coronary artery disease while Respondent was seeing him three and four times per week prior to his death. The Board asked what service Respondent rendered to RW who had serious life threatening problems that killed him while Respondent was charging for comprehensive examinations that did not appear to do anything for RW. Respondent disagreed that he did nothing for RW and stated if RW had come in when Respondent asked him to he does not think RW would have died. The Board noted RW was coming to Respondent three or four times per week and Respondent had multiple occasions to address the issues.

21. The Board asked if Respondent had other patients during the time he was treating RW. Respondent testified he had other patients and he would have to reschedule them on occasion when RW came into the office and was disruptive. Respondent acknowledged he could have refused to accept RW as a patient and could have applied to the Court to be relieved of any obligation. The Board noted it appeared RW's many medical issues were not being addressed. Respondent testified RW was often like a wild man, was obsessive compulsive, and was very difficult to deal with.

22. The Board asked about treating RW with Kenalog and whether this was the way Addison's disease or adrenaline insufficiency should be treated. Respondent testified it was appropriate if the patient was in a crisis. The Board asked how Respondent made the diagnosis of adrenalin insufficiency. Respondent testified he measured RW's morning cortisol and knew he

had a history of pituitary surgery. The Board asked if RW measured the cortisol every time he saw RW. Respondent testified he measured it one time. The Board noted Respondent gave the Kenalog from time to time and asked how Respondent decided when to administer it. Respondent testified he would give it if RW was quite ill, if he was short of breath, or if his asthma kicked in. The Board asked if RW got Kenalog every time he came to Respondent and was short of breath. Respondent testified he gave RW Kenalog to try and help with his asthma or whatever the problem was because RW may very well have been cortisol deficient. The Board noted it did not see a coordinated plan to treat RW. Respondent testified the Board was missing that some of the information would be in the appointment book, some of it is in the daily log of telephone calls and he would have seen those things before he saw the progress note. The Board asked if Respondent was saying the way he treats various conditions would be in his appointment book. Respondent testified why a patient is coming in is usually denoted in the appointment book and sometimes it is not what the patient says when he/she arrives.

23. The Board reminded Respondent of his earlier testimony that he tried to get RW to come to see him the Thursday and Friday before RW died, but he was unable to. Respondent confirmed that was his testimony. The Board then directed Respondent to his super bill for the month of March and noted Respondent billed for a visit on the Thursday and Friday before RW died, and in fact billed for almost every day of the month even when there were no progress notes to match the billing. Respondent agreed and the Board asked him to explain. Respondent testified some of it was on the super bill itself, some of it was on the telephone calls, which were very lengthy with attorneys and the trust officer and the mother's attorney. Respondent testified one of the last entries on the Thursday or Friday reflects a call from RW's mother's attorney asking to get together to discuss how RW was being handled. Respondent testified he was just trying to get RW through the process and it is not pretty and it is not simple. Respondent testified

that looking at his progress notes, the super bill, patient instruction sheet, and the pill count sheet gives a much clearer picture.

24. The Board asked the purpose of the labs he ordered for RW, other than following things. Respondent testified RW had multiple illnesses and he followed multiple things that might go wrong – partly following the patient for his disease and partly following his total undependability. The Board asked if part of ordering labs was for purposes of treating something you might diagnose. Respondent agreed. The Board noted there was no treatment plan in Respondent's notes and nowhere in the record did he diagnose Addison's disease and note the corresponding treatment recommendation or asthma and the corresponding treatment recommendation. The Board noted most of the labs ordered between September 4, 2001 and December 28, 2001 were abnormal, but there was no treatment plan. The Board asked what Respondent was doing with the results of all the labs. Respondent testified there were a lot of tests and a lot of visits and the notes themselves are a reflection of what happens when a doctor is in solo practice for so long and never has anyone critique what he is doing. Respondent testified he had his methods of having all the information, but it was spread all over the place. Respondent noted duplicating things becomes very boring when there is no one else to see it and so he would not necessarily write out all the abnormal lab results in the progress notes and have them right next to him as they came from the lab.

25. The Board noted Respondent paid the lab $29.75 for PSA, but billed the trust $95.00 and paid $36 for a TSH, which he did on almost every visit, but billed the trust $162.00. The Board asked if Respondent had a financial incentive for ordering all the labs. Respondent testified he did not know the cost of any of the tests until the Board asked him to supply the lab charge and what he received. Respondent testified he did not realize the difference between what he paid for the test and what the patient was billed. The Board noted it could not determine the medical reason for the ordered tests, but did see the financial gain to Respondent. The Board

also noted Respondent based no medical decisions off the tests and whether they were abnormal or not, they were ordered again three of four days later. Respondent testified most of the tests were requested by RW. The Board noted Respondent was the physician and was the one who decided what tests to order and when and why.

26. The Board asked if it was correct that Respondent realized the level of service he was performing was not a 99215, but he was submitting it to Blue Cross as a 99215 so he could help the trust in obtaining maximum reimbursement from the insurance company. Respondent testified that is not what he said earlier and what he said was if the time or complexity met or exceeded the requirements for 99215 he would use it because it was the only one available if RW was in his office for over one hour. Respondent testified he was not trying to fool anyone and was just trying to bill accordingly for the amount of time and effort he and his staff put into RW on a given occasion.

27. The Board asked how Respondent, knowing what he knows now, would change his practice in facing a patient like RW. Respondent testified he would not take the patient and would avoid it at all costs. Respondent testified he has been through four years of discomfort and is extremely uncomfortable having to sit before the Board. Respondent noted his attorney told him that "records were everything" and that hit him like an arrow. Respondent testified he slowly got into a situation where he felt he was repeating things over and over and he went from fairly decent record-taking to something that is not acceptable.

28. Respondent inappropriately prescribed mixtures of drugs that were contraindicated and prescribed controlled substances without documentation to a patient who had undergone detoxification for substance abuse and chemical dependency. RW presented to Respondent over his last ten office visits with progressive dyspnea that Respondent did not address.

29. The standard of care requires timely and accurate assessment of a patient's symptoms and appropriate intervention and treatment of a patient's substance abuse.

30. Respondent deviated from the standard of care because he failed to diagnose and treat RW's bronchopneumonia and failed to appropriately treat RW's substance abuse.

31. Respondent's failure contributed significantly to RW's death.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. §§ 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); 32-1401(27)(w) ("[c]harging or collecting a clearly excessive fee . . . ."); and 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Decree of Censure for inappropriate billing, inadequate medical records, mismanagement of an addicted patient, and failure to diagnose and treat pneumonia in a timely fashion contributing to the death of a patient.

2. Respondent is placed on probation for two years with the following terms and conditions:

a. Within one year Respondent shall obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in record keeping, billing and coding.

Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of medical license.

b. Board Staff or its agents shall conduct a chart review at the conclusion of one year from the effective date of this Order. The Board retains jurisdiction to take additional disciplinary or remedial action based upon the results of the chart review.

c. Within 180 days of the effective date of this Order Respondent shall submit to an evaluation by the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego. Any and all reports, assessments or other documents generated by PACE shall be forwarded by PACE to the Board for review. Respondent is to undergo the evaluation at his expense. The Board retains jurisdiction and may initiate new action based upon the results of the PACE evaluation. Respondent shall provide a copy of this Order to PACE.

d. Within 60 days of the effective date of this Order Respondent shall pay a civil penalty in the amount of $5,000.

e. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board stating whether there has been compliance with all the conditions of probation. The declarations must be submitted on or before the 15th of March, June, September and December of each year.

f. In the event Respondent should leave Arizona to reside or practice or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent

residence or practice outside Arizona or of non-practice within Arizona will not apply to the reduction of the probationary period.

g. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 9th day of June, 2006.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 9th day of June, 2006 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
9th day of June, 2006, to:

Charles Buri
Friedl, Richter & Buri, PA
6909 East Greenway Parkway – Suite 200
Phoenix, Arizona 85254-2131

Executed copy of the foregoing
mailed by U.S. Mail this
9th day of June, 2006, to:

John Hensler, M.D.
Address of Record